Catholic Health System

Patient Identification Information

❑ SISTERS OF CHARITY HOSPITAL • Buffalo, NY ❑ SISTERS OF CHARITY HOSPITAL ST JOSEPH Campus • Cheektowaga, NY
❑ KENMORE MERCY HOSPITAL • Kenmore, NY ❑ MERCY HOSPITAL • Buffalo, NY ❑ MERCY HOSPITAL Orchard Park division • Orchard Park, NY

Allergies & Sensitivities:

❑ **No Known Allergies** ☑ **(Indicates automatic order. MD to draw line through orders to discontinue)**

Initial Endotracheal Intubation Orders

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS

☑ Chest x-ray to check ET tube placement

☑ Patient NPO
❑ Insert NG
❑ Nutritional Consult for feeding recommendations

☑ Elevate head of bed 30 – 45 degrees ; unless contraindicated : _____

☑ Oral care with oral care kits for ventilated patients per policy

☑ Chlorhexidine mouthwash 15 mL PO every 12 hours

☑ ABG 30 minutes post intubation/ventilation

Venous Thromboembolism Precautions: (VTE) (Check all that apply)
❑ Sequential Compression Device
❑ Enoxaparin (Lovenox) 40 mg subcutaneous q daily
❑ Heparin 5000 units subcutaneous every 8 hours
❑ Heparin 5000 units subcutaneous every 12 hours
❑ Other _____
❑ Patient requires full therapeutic anticoagulation (Heparin protocol –use standard order form)
❑ No VTE Prophylaxis (REASON: ❑ Not a Candidate ❑ Contraindicated: _____ ❑ Other _____)

Consults/Referrals:
❑ Pulmonary/Critical Care Consult: _____ ❑ Physical Therapy evaluation and treatment

Sedation/Analgesia:
❑ Analgesia: (drug, dose frequency, reason)
_____
❑ Intermittent Analgesia PRN: (drug, dose frequency, reason)
_____
❑ Intermittent Sedation PRN: (drug, dose frequency, reason) _____
_____

Initial Ventilator Settings:
FIO2: _____ Mode: _____Ventilator Rate: _____ Tidal Volume: _____ PEEP: 5cm H20 or _____
(Plateau pressure should be less than 35 cm of water pressure if possible)
(Recommend 6-10 mL/kg: use predicted body weight*)

Stress Ulcer Prophylaxis:
❑ Pantoprazole (Protonix) 40 mg IV every 24 hours
❑ Famotidine (Pepcid) 20 mg IV every 12 hours

Additional Orders:

Prescriber Signature:_____

Developed 4/09